

Hallucination: Denied None evidenced  
 Thought content: Within normal limits  
 Delusions: None Reported  
 Cognition: Within normal limits  
 Intelligence estimate: Average  
 Insight: Within normal limits  
 Judgment: Within normal limits

### Subjective Information

New issues/stressors/extraordinary events presented today: None reported

Explanation: Patient was seen in MHP's office for her HCR submitted 5/17/22, received/screened 5/18/22 (routine), stating "I would like to speak with Ms. Martinez, Thanks in advance." During session, patient detailed traumatic events that she experienced as a child. She discussed her current charge and she processed her thoughts on her progress. Patient acknowledged having interpersonally exploitative traits and stated that she has tried to use them to her advantage. She discussed her upbringing in foster care and being separated from her siblings. Patient said that she would be open to participating in a mental health group should the opportunity arise. She expressed interest in being part of a mental health group focused on the LGBTQ population.

### Goals, Objectives, and Interventions Addressed Today

Interventions/Methods Provided:

Practiced active listening while patient discussed her past trauma.

Inquired about patient's coping mechanisms and how she continues utilizing make up as a coping skill.

Encouraged patient to continue being proactive in her mental health treatment.

Praised patient for being self reflective and processing her emotions.

Response to Interventions/Progress Toward Goals and Objectives:

Patient remained cooperative and respectful throughout the session. she was receptive to feedback given by MHP.

### Current Assessment

Individual's progress: Some progress

### Assessment:

Anxiety is not significant. Cognitive issues are not significant. Substance abuse/dependence is not significant. Depression is not significant. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania/manic behavior is not significant. Patient is responding to treatment plan. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

### Risk Assessment

#### CURRENT ENCOUNTER

##### Risk Assessments

Patient denies suicidal ideation, plan, intent, and/or attempt.

Patient denies property damage ideation, plan, intent, and/or attempt.

Patient denies homicidal ideation, plan, intent, and/or attempt.

#### RISK ASSESSMENT HISTORY

Risk	Current	Past	Documented	Event Date	Approximate Date	Ideation	Plan	Intent	Scale
Suicide	Denies		05/24/2022	05/24/2022	No				
Property	Denies		05/24/2022	05/24/2022	No				
Homicide	Denies		05/24/2022	05/24/2022	No				

Patient Name: RICHARDSON, JONATHAN  
 ID: 127630 Date of Birth: [REDACTED]

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 Encounter Date: 05/24/2022 04:12 PM

Attempt	Planned/ Impulsive	Drug/Alcohol Influenced	Medically Treated	Plan Attempt Description
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#### SAFETY MANAGEMENT PLAN

No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

#### Assessment/Diagnosis

AXIS IV

Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

AXIS V

Current GAF: 70

Date: 07/01/2021.

Highest GAF: 70

Date: 05/03/2021.

#### Plan and Additional Information

Date	Order Description
08/22/2022	MHP follow-up for MH Monitoring

#### SIGNATURES

Staff: Signed by Leticia Martinez-Mateos, MSW, LSW on 05/24/2022

#### Behavioral Health Billing

Start time: 10:05 AM  
End time: 10:55 AM  
Duration: 00 hours, 50 minutes  
Modifier: N/A

Document generated by: Leticia Martinez-Mateos 05/24/2022 04:20 PM

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302 W. Washington Street  
Indianapolis, IN 46204

Patient Name: RICHARDSON, JONATHAN  
ID: 127630 Date of Birth: [REDACTED]

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Patient Name: RICHARDSON, JONATHAN  
ID: 127630 Date of Birth: [REDACTED]

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**State of Indiana**

Department of Correction

Division of Medical and Clinical Healthcare Services

Indiana Government Center South  
302 W. Washington Street  
Indianapolis, IN 46204

**Facility: CIC**

PATIENT: JONATHAN RICHARDSON  
DATE OF BIRTH: [REDACTED]  
DOC #: 127630  
DATE: 05/07/2022 12:15 PM  
VISIT TYPE: Nurse Visit

**Nurse Visit**

Reason for visit: FER needed

**Nurse Protocols:**

**Review/Comments**

Patient smokes 16.00 packs a year

**Medications**

Medication	Sig	PRN Status	PRN Reason	Comment
estradiol 2 mg tablet	take 2 tablet by oral route every day	N		
Proventil HFA 90 mcg/actuation aerosol inhaler	inhale 2 puff by inhalation route every 4 - 6 hours as needed	Y		
spironolactone 100 mg tablet	take 1 tablet by oral route every day	N		
Zocor 10 mg tablet	take 1 tablet by oral route every day in the evening	N		

**General Comments**

FERS submitted for Estradiol and Spironolactone  
FERS approved per Dr Wilks

Document generated by: Shannon S. McCord, LPN 06/16/2022 12:17 PM

Indiana Government Center South

Patient Name: RICHARDSON, JONATHAN  
ID: 127630 Date of Birth: [REDACTED]

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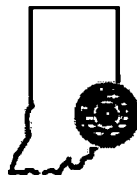
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302 W. Washington Street  
Indianapolis, IN 46204

Patient Name: RICHARDSON, JONATHAN  
ID: 127630 Date of Birth: [REDACTED]

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**State of Indiana**

Department of Correction

Division of Medical and Clinical Healthcare Services

Indiana Government Center South  
302 W. Washington Street  
Indianapolis, IN 46204

**Facility: CIC**

PATIENT: JONATHAN RICHARDSON  
DATE OF BIRTH: [REDACTED]  
DOC#: 127630  
DATE: 05/05/2022 10:34 AM  
VISIT TYPE: Provider Visit

Established patient

Clinic	Additional	Enroll Date	Last Visit Date	Dis-enroll Date	Dis-enroll Reason
Asthma		01/14/2020		05/05/2022	
Asthma		04/08/2020		05/05/2022	

The following conditions were addressed during this chronic care visit:

Asthma  
Other

**History of Present Illness:**

1. Gender dysphoria  
She stated tolerating estradiol well, budding and is a b cup.
2. Hyperlipidemia  
Risk factors include sedentary life style. Additional information: stated do not like to take medications but after discussion about high cholesterol agreed.
3. asthma  
The initial visit date was 02/12/2008. Symptoms of asthma began in 1984. Additional information: pt stated had asthma as a kid and stated has not used an inhaler in years and has been stable without one and does not have a proair on hand or want one. She feels do not need to be on CCC for athma anymore.
4. seiures  
she stated all the seizure medications offered on formulary are intolerable and do not want to take any medication for seizures. She reports no seizures awake from sleep like used to, cellmate may see occassional jerking in her sleep.

**PROBLEM LIST:**

Problem Description	Onset Date	Chronic	Clinical Status	Notes
Gender identity disorder of adulthood	06/17/2020	N		
Gastroesophageal reflux disease	02/19/2015	Y		Mapped from KBM Chronic Conditions table on 05/09/2016 by the ICD9 to SNOMED Bulk Mapping Utility. The mapped diagnosis code was Esophageal reflux, 530.81, added by Paul A. Talbot, MD, with responsible provider Paul A. Talbot

RICHARDSON, JONATHAN 127630 [REDACTED] 05/05/2022 10:34 AM 256/291

Borderline personality disorder 05/04/2010 Y

MD. Onset date 02/19/2015.  
Mapped from KBM Chronic Conditions table on 05/09/2016 by the ICD9 to SNOMED Bulk Mapping Utility. The mapped diagnosis code was Borderline personality disorder, 301.83, added by Darla Hinshaw, MD, with responsible provider .  
Onset date 05/04/2010; Axis II.

Recurrent major depressive episodes, mild 10/21/2019 N

Problem List (not yet mapped to SNOMED-CT®):

Problem Description	Onset Date	Notes
Asthma	03/19/2007	
Polysubstance Dependence	01/17/2011	
major depression in remission	01/17/2011	
Nonspecific reaction to tuberculin skin test witho	02/01/2011	
Epilepsy	06/11/2015	

Allergies

Ingredient	Reaction	Medication Name	Comment
IBUPROFEN	Rash		
PENICILLINS	Rash		
CEFTRIAZONE SODIUM	SOB, chest pressure, rash	ROCEPHIN	Pt was given 0.5mg Epi x1 and NS IV w/ good results

Review of Systems

System	Neg/Pos	Details
Respiratory	Negative	Dyspnea.
Cardio	Negative	Chest pain and edema.
GI	Negative	Abdominal pain.

Vital Signs

Weight/BSA/BMI

Time	lb	oz	kg	Context	BMI kg/m2	BSA m2
11:12 AM	215.0		97.522			

Blood Pressure

Time	BP mm/Hg	Position	Side	Site	Method	Cuff Size
11:12 AM	140/83					

Temperature/Pulse/Respiration

Time	Temp F	Temp C	Temp Site	Pulse/min	Pattern	Resp/ min
11:12 AM	97.30	36.3		93		16

Pulse Oximetry/FIO2

RICHARDSON, JONATHAN 127630 05/05/2022 10:34 AM 257/291

# 1159

Time	Pulse Ox (Rest %)	Pulse Ox (Amb %)	O2 Sat	O2 L/Min	Timing	FiO2 %	L/min	Delivery Method	Finger Probe
11:12 AM	98								

**Measured By**

Time	Measured by
11:12 AM	Vernon L Osburn, NP

**Physical Exam**

Exam	Findings	Details
Respiratory	Normal	Auscultation - Normal.
Cardiovascular	Normal	Heart rate - Regular rate. Rhythm - Regular. Heart sounds - Normal S1, Normal S2. Murmurs - None. Extremities - No edema.
Abdomen	Normal	No abdominal tenderness.
Extremity	Normal	No edema.

**Suicide Risk Screening****Assessment/Plan**

#	Detail Type	Description
1.	Assessment	Asthma (493).
	Patient Plan	The patient verbalized an understanding of the plan.
	Provider Plan	consider peak flow at next visit and if acceptable range consider discharge from CCC for this dx as been stable w/o inhaler
2.	Assessment	Epilepsy (345).
	Patient Plan	The patient verbalized an understanding of the plan.
	Provider Plan	At this time pt is not ope to being on anti-seizure medications but if seizures recur may consider EEG and/or treatment

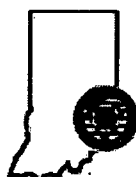
APR 05/2022	APR 05/2022	APR 05/2022	APR 05/2022	APR 05/2022	APR 05/2022	APR 05/2022	APR 05/2022	APR 05/2022	APR 05/2022
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Osburn, Vernon L 05/05/2022 11:21 AM

Document generated by: Vernon L Osburn, NP 05/05/2022 11:21 AM

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Indianapolis, IN 46204

**Facility: CIC**

PATIENT: JONATHAN RICHARDSON  
DATE OF BIRTH: [REDACTED]  
DOC#: 127630  
DATE: 04/26/2022 6:37 AM  
VISIT TYPE: Onsite Consult

### INDIVIDUALIZED ACTION PLAN

Program name:

Admission date: 06/09/2016

Effective date of initial IAP:

Next review date: 10/27/2022

### GOALS, OBJECTIVES AND INTERVENTIONS

**Goal 3: Depressive symptoms do not impair daily functioning (continued)**

Target date: 10/27/2022

Adjusted target date: 09/07/2017 (Adjusted as per IAP review dated 05/01/2018)

Assessed need: Depression

Individual's strength/skills: {local.txt\_stengths}

Potential barriers: {local.txt\_barriers}

- Objective 1: Identifies negative thinking supporting depression (continued)

Start date: 06/30/2012

Target date: 10/27/2022

Adjusted target date: 09/07/2017 (Adjusted as per IAP review dated 05/01/2018)

-- Intervention 1: LGBTQ group

Modality: Group therapy      Frequency: prn      Type of provider: MHP

- Objective 2: Verbalizes increased feelings of self worth (continued)

Start date: 06/30/2012

Target date: 10/27/2022

Adjusted target date: 09/07/2017 (Adjusted as per IAP review dated 03/07/2017)

-- Intervention 2: LGBTQ Group

Modality: Group therapy      Frequency: prn      Type of provider: MHP

Patient Name: RICHARDSON, JONATHAN  
ID: 127630      Date of Birth: [REDACTED]

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**Goal 4: Mismatch between assigned gender and gender identity no longer causes marked distress. (continued)**

Start date: 07/22/2019

Target date: 10/27/2022

Assessed need: Evaluation for gender dysphoria

Individual's strength/skills: {local.txt\_strengths}

Potential barriers: {local.txt\_barriers}

- Objective 1: Identify ways in which gender identity leads to distress, exacerbates symptoms of depression, and contributes to other concerns such as irritability and self-destructive behavior. (continued)

Start date: 08/27/2020

Target date: 10/27/2022

Adjusted target date: (Adjusted as per IAP review dated 05/01/2018)

-- Intervention 1: Person-centered, supportive, solution-focused interventions. LGBTQ Group

Modality: Group therapy

Frequency: prn

Type of provider: Psychologist

**TRANSITION/DISCHARGE CRITERIA**

Discharge plan:

4/26/22: TP updated to reflect group therapy needs.

8/23/21: Patient Autumn (Richardson) was seen for her 90 day routine monitoring and TPR. She denied significant mental health concerns, but acknowledged symptoms of grief over her two best friends being moved to another facility. She described being grateful to them for accepting who she is. She will continue to be monitored every 90 days.

8/27/20 - Richardson has been diagnosed with gender dysphoria and started hormone therapy. She has shown an improvement in mood, irritability, and interpersonal relatedness. An overarching goal for the next treatment period will be to continue to explore and grow into her role living as a woman.

Individual has participated in the development of this plan:

Yes

Others participated in the development of this plan:

No

Patient Name: RICHARDSON, JONATHAN.  
ID: 127630 Date of Birth: [REDACTED]

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**SIGNATURES**

**Staff:** Signed by Leticia Martinez Mateos, MSW, LSW on 04/27/2022

*Document generated by: Leticia Martinez Mateos 04/27/2022 06:59 AM*

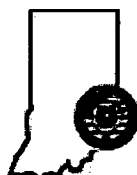
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Patient Name: RICHARDSON, JONATHAN  
ID: 127630 Date of Birth: [REDACTED]

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**State of Indiana**

**Department of Correction**

Division of Medical and Clinical Healthcare Services

Indiana Government Center South  
302 W. Washington Street  
Indianapolis, IN 46204

**Facility: CIC**

PATIENT: JONATHAN RICHARDSON  
DATE OF BIRTH: [REDACTED]  
DOC #: 127630  
DATE: 04/26/2022 6:37 AM  
HISTORIAN: self  
VISIT TYPE: Onsite Consult

**Individual Counsel/Psych Prog Note**

**General**

Program Name: Outpatient

HCR#: 278077

Start time: 10AM

**MENTAL STATUS EXAM**

**GENERAL OBSERVATIONS:**

Generally normal

Appearance: Within normal limits

Build/Stature: Within normal limits

Posture: Within normal limits

Eye Contact: Average

Activity: Within normal limits

Attitude toward examiner: Cooperative

Attitude toward parent/guardian: Not Applicable

Separation (for children/adolescent): Not applicable

**MENTAL STATUS:**

Unremarkable

Mood: Euthymic

Affect: Full

Speech: Clear

Thought process: Logical

Perception: WNL

Hallucination: Denied None evidenced

Thought content: Within normal limits

Delusions: None Reported

Cognition: Within normal limits

Patient Name: RICHARDSON, JONATHAN

ID: 127630 Date of Birth: [REDACTED]

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Encounter Date: 04/26/2022 06:37 AM

STATE001283

Intelligence estimate: Average  
 Insight: Within normal limits  
 Judgment: Within normal limits

### Subjective Information

New issues/stressors/extraordinary events presented today: New issue resolved, no update required

Explanation: Patient was seen in MHP's office for her HCR submitted 4/20/22, received/screened 4/22/22 (routine), stating "I would like to see Ms. Martinez". During session, patient acknowledged issues with the LGBTQ community as she stated that she has been experiencing an increase in harassment in her unit. Patient acknowledged that she has been applying makeup in the bathroom as she has been embracing her femininity. Meanwhile, other incarcerated individuals have been writing the word "fag" in the bathroom she uses. Patient denied knowing who specifically is writing these words. She stated that she has been overcoming this harassment by continuing to use makeup as her therapeutic outlet. She expressed pride in herself and acknowledged her strengths.

### Goals, Objectives, and Interventions Addressed Today

Goal Today	Objective Today
Depressive symptoms do not impair daily functioning	Identifies negative thinking supporting depression

### Interventions/Methods Provided:

MHP utilized active listening while patient discussed her current barriers.  
 Provided feedback regarding her coping strategies and praised her for utilizing makeup as a therapeutic outlet.  
 Encouraged patient to continue practicing assertiveness.  
 Spoke with patient regarding joining an LGBTQ mental health group.  
 Response to Interventions/Progress Toward Goals and Objectives:  
 Patient remained cooperative and respectful throughout the session. She was receptive to feedback given by MHP.

### Current Assessment

Individual's progress: Some progress

### Assessment

Anxiety is not significant. Cognitive issues are not significant. Substance abuse/dependence is not significant. Depression is not significant. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania/manic behavior is not significant. Patient is responding to treatment plan. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

### Risk Assessment

#### CURRENT ENCOUNTER

Risk Assessments
Patient denies suicidal ideation, plan, intent, and/or attempt.
Patient denies property damage ideation, plan, intent, and/or attempt.
Patient denies homicidal ideation, plan, intent, and/or attempt.

#### RISK ASSESSMENT HISTORY

Risk	Current	Past	Documented	Event Date	Approximate Date	Ideation	Plan	Intent	Scale
Suicide	Denies		04/26/2022	04/26/2022	No				
Property	Denies		04/26/2022	04/26/2022	No				
Homicide	Denies		04/26/2022	04/26/2022	No				

Patient Name: RICHARDSON, JONATHAN  
 ID: 127630 Date of Birth: [REDACTED]

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 Encounter Date: 04/26/2022 06:37 AM

Attempt	Planned/ Impulsive	Drug/Alcohol Influenced	Medically Treated	Plan Attempt Description
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#### SAFETY MANAGEMENT PLAN

No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

#### Assessment/Diagnosis

AXIS IV

Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

AXIS V

Current GAF: 70

Date: 07/01/2021.

Highest GAF: 70

Date: 05/03/2021.

#### Plan and Additional Information

Date	Order Description
07/25/2022	MHP follow-up for MH Monitoring

Plan/Additional Information:

Patient will be signed up for an LGBTQ mental health group PRN.

#### SIGNATURES

Staff: Signed by Leticia Martinez Mateos, MSW, LSW on 04/27/2022

#### Behavioral Health Billing

Start time: 10AM  
End time: 10:30AM  
Modifier: N/A

Document generated by: Leticia Martinez Mateos 04/27/2022 06:53 AM

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Patient Name: RICHARDSON, JONATHAN  
ID: 127630 Date of [REDACTED]

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STATE001285

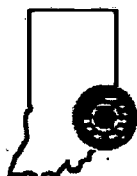
Patient Name: RICHARDSON, JONATHAN  
ID: 127630 Date of Birth: [REDACTED]

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Encounter Date: 04/26/2022 06:37 AM

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**SPECIAL NEEDS / URGENT ORDERS**

**SITE: CIC**



**State of Indiana**

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**Division of Medical and Clinical Healthcare Services**

**Indiana Government Center South  
302 W. Washington Street  
Indianapolis, IN 46204**

**Facility: CIC**

**PATIENT: JONATHAN RICHARDSON**  
**DOB: [REDACTED]**  
**DOC#: 127630**  
**DATE: 04/15/2022 11:09 AM**  
**DOCUMENT GENERATED BY: Abiola Amusan, RN**

**Classification Orders**

<b>Order</b>	<b>Reason</b>	<b>Status</b>	<b>Start</b>	<b>End</b>
Bottom bunk	RUE DEFORMITY	ordered	04/06/2022	10/06/2022
laying from work only		ordered	04/15/2022	04/17/2022

Indiana Government Center South  
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Indianapolis, IN 46204

**NAME: RICHARDSON, JONATHAN**

**NUMBER: 127630**

**D.O.B: [REDACTED]**

**STATE001287**





# State of Indiana

Department of Correction

Division of Medical and Clinical Healthcare Services

Indiana Government Center South  
302 W. Washington Street  
Indianapolis, IN 46204

Facility: CIC

PATIENT: JONATHAN RICHARDSON  
DATE OF BIRTH: [REDACTED]  
DOC #: 127630  
DATE: 04/15/2022 11:09 AM  
VISIT TYPE: Nurse Visit

## Nurse Visit

Reason for visit: Abdominal pain

Statement of complaint (in patient's words): Frequent stooling over 24hrs

## Vital Signs

### Weight/BSA/BMI

Time	lb	oz	kg	Context	BMI kg/m2	BSA m2
11:13 AM	226.5		102.739			

### Blood Pressure

Time	BP mm/Hg	Position	Side	Site	Method	Cuff Size
11:13 AM	117/85					

### Temperature/Pulse/Respiration

Time	Temp F	Temp C	Temp Site	Pulse/min	Pattern	Resp/min
11:13 AM	97.30	36.3		82		18

### Pulse Oximetry/FIO2

Time	Pulse Ox (Rest %)	Pulse Ox (Amb %)	O2 Sat	O2 L/Min	Timing	FiO2 %	L/min	Delivery Method	Finger Probe
11:13 AM	98		RA						

### Measured By

Time	Measured by
11:13 AM	Jodean Ayres, RN

### Nurse Protocols:

EMERGENCY NURSING ABDOMINAL PAIN

Patient Name: RICHARDSON, JONATHAN  
ID: 127630 Date of Birth: [REDACTED]

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Encounter Date: 04/15/2022 11:09 AM

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**Objective:**

**Distress** no acute distress

**Orientation** alert

**Skin exam** warm

**Abdomen Exam**

Auscultation Bowel sounds present

Palpation soft non-tender

**Assessment: Abdominal pain**

**The following nursing interventions were completed**

Medication allergies reviewed; pregnancy ruled out

Patient education provided

**Follow-up:**

Sick call if symptoms do not subside or become worse

**Review/Comments**

Patient smokes 16.00 packs a year

**Medications**

Medication	Sig	PRN Status	PRN Reason	Comment
estradiol 2 mg tablet	take 1 tablet by oral route every day	N		
spironolactone 50 mg tablet	take 1 tablet by oral route every day	N		
Tylenol Extra Strength 500 mg tablet	take 1 tablet by oral route every 8 hours as needed	N		

**Orders**

Status	Order	Timeframe	Frequency	Duration	Stop Date
ordered	Return to Housing Unit				
ordered	laying from work only				04/17/2022

**General Comments**

He complains of abdominal pain with frequent stooling over 24hrs, not in obvious distress at the moment, educated on importance of hand hygiene and to return to NSC if condition changes. Lay of from work given from work (kitchen) till sunday.

Patient Name: RICHARDSON, JONATHAN  
ID: 127630 Date of Birth: [REDACTED]

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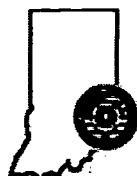
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Indiana Government Center South  
302 W. Washington Street  
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Patient Name: RICHARDSON, JONATHAN  
ID: 127630 Date of Birth: [REDACTED]

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STATE001290



**State of Indiana**

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Division of Medical and Clinical Healthcare Services

Indiana Government Center South  
302 W. Washington Street  
Indianapolis, IN 46204

**Facility: CIC**

PATIENT: JONATHAN RICHARDSON  
DATE OF BIRTH: [REDACTED]  
DOC #: 127630  
DATE: 04/13/2022 9:34 AM  
VISIT TYPE: Nurse Visit

**Nurse Visit**

Reason for visit: Med Renewal

**Nurse Protocols:**

**Review/Comments**

Patient smokes 16.00 packs a year

**Medications**

Medication	Sig	PRN Status	PRN Reason	Comment
estradiol 2 mg tablet	take 1 tablet by oral route every day	N		
spironolactone 50 mg tablet	take 1 tablet by oral route every day	N		
Tylenol Extra Strength 500 mg tablet	take 1 tablet by oral route every 8 hours as needed	N		

**General Comments**

CC Rx Renewal

Document generated by: Shannon S. McCord, LPN 04/13/2022 09:35 AM

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Patient Name: RICHARDSON, JONATHAN  
ID: 127630 Date of Birth: [REDACTED]

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Encounter Date: 04/13/2022 09:34 AM

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Electronically signed by Vernon L. Osburn NP on 08/17/2022 04:45 PM

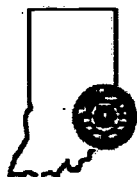
Patient Name: RICHARDSON, JONATHAN  
ID: 127630 Date of Birth: [REDACTED]

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Encounter Date: 04/13/2022 09:34 AM

STATE001292

**SPECIAL NEEDS / URGENT ORDERS**

**SITE: CIC**



**State of Indiana**

Division of Medical and Clinical Healthcare Services

Department of Correction

Indiana Government Center South  
302 W. Washington Street  
Indianapolis, IN 46204

**Facility: CIC**

PATIENT: JONATHAN RICHARDSON  
DOB: [REDACTED]  
DOC#: 127630  
DATE: 04/06/2022 1:21 PM  
DOCUMENT GENERATED BY: Tina Collins, RN

**Classification Orders**

Order	Reason	Status	Start	End
Bottom bunk	RUE DEFORMITY	ordered	04/06/2022	10/06/2022

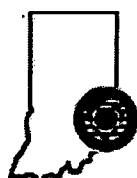
Indiana Government Center South  
302 W. Washington Street  
Indianapolis, IN 46204

NAME: RICHARDSON, JONATHAN

NUMBER: 127630

D.O.B: [REDACTED]

STATE001293



**State of Indiana**

Department of Correction

Division of Medical and Clinical Healthcare Services

Indiana Government Center South  
302 W. Washington Street  
Indianapolis, IN 46204

**Facility: CIC**

PATIENT: JONATHAN RICHARDSON  
DATE OF BIRTH: [REDACTED]  
DOC #: 127630  
DATE: 04/06/2022 1:21 PM  
VISIT TYPE: Nurse Visit

**Nurse Visit**

Reason for visit: Special Needs Order

**Nurse Protocols:**

**Review/Comments**

Patient smokes 16.00 packs a year

**Medications**

Medication	Sig	PRN Status	PRN Reason	Comment
estradiol 2 mg tablet	take 1 tablet by oral route every day	N		
spironolactone 50 mg tablet	take 1 tablet by oral route every day	N		
Tylenol Extra Strength 500 mg tablet	take 1 tablet by oral route every 8 hours as needed	N		

**Orders**

Status	Order	Timeframe	Frequency	Duration	Stop Date
ordered	Bottom bunk				10/06/2022

**General Comments**

BBP DUE TO R HAND MISSING 2 DIGITS - THUMB AND INDEX FINGER

Document generated by: Tina Collins, RN 04/06/2022 01:29 PM

Patient Name: RICHARDSON, JONATHAN  
ID: 127630 Date of Birth: [REDACTED]

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Encounter Date: 04/06/2022 01:21 PM

STATE001294

Indiana Government Center South  
302 W. Washington Street  
Indianapolis, IN 46204

Electronically signed by John Jones MD on 04/07/2022 08:51 AM

Patient Name: RICHARDSON, JONATHAN  
ID: 127630 Date of Birth: [REDACTED]

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Encounter Date: 04/06/2022 01:21 PM

STATE001295



**State of Indiana**

Department of Correction

Division of Medical and Clinical Healthcare Services

Indiana Government Center South  
302 W. Washington Street  
Indianapolis, IN 46204**Facility: CIC**

PATIENT: JONATHAN RICHARDSON  
DATE OF BIRTH: [REDACTED]  
DOC #: 127630  
DATE: 03/31/2022 1:34 PM  
HISTORIAN: self  
VISIT TYPE: Onsite Consult

**Individual Counsel/Psych Prog Note****General**

Program Name: Outpatient

HCR#: 10446

Start time: 10AM

**MENTAL STATUS EXAM****GENERAL OBSERVATIONS:**

Generally normal

Appearance: Within normal limits

Build/Stature: Within normal limits

Posture: Within normal limits

Eye Contact: Average

Activity: Within normal limits

Attitude toward examiner: Cooperative

Attitude toward parent/guardian: Not Applicable

Separation (for children/adolescent): Not applicable

**MENTAL STATUS:**

Mood: Depressed

Affect: Constricted

Speech: Clear

Thought process: Logical

Perception: WNL

Hallucination: Denied None evidenced

Thought content: Within normal limits

Delusions: None Reported

Cognition: Within normal limits

Intelligence estimate: Average

Patient Name: RICHARDSON, JONATHAN  
ID: 127630 Date of Birth: [REDACTED]Page 275 of 291  
Encounter Date: 03/31/2022 01:34 PM

Insight: Within normal limits  
Judgment: Within normal limits

### Subjective Information

Explanation: Patient was seen for her HCR submitted 3/21/22, received/screened 3/24/22 (routine), stating "I would like to see Ms. Martinez". During session, patient processed her childhood trauma and current prejudices that she has been exposed to. Patient discussed being a survivor and moving away from the victim mentality. She described her strengths and acknowledged that her experiences have made her stronger and more capable. Patient stated that she perceives one of her strengths to be her vulnerability but she does not often get to practice it due to her prison environment.

### Goals, Objectives, and Interventions Addressed Today

Goal Today	Objective Today
Depressive symptoms do not impair daily functioning	Identifies negative thinking supporting depression

#### Interventions/Methods Provided:

Actively listened to patient as he described his barriers.  
Encouraged patient to continue practicing recognizing her strengths.  
Inquired about patient's progress in the last two months.  
Validated patient's thoughts, feelings and experiences.

#### Response to Interventions/Progress Toward Goals and Objectives:

Patient remained cooperative and respectful throughout the session. He was receptive to feedback given by MHP.

### Current Assessment

Individual's progress: Some progress

#### Assessment:

Anxiety is not significant. Cognitive issues are not significant. Substance abuse/dependence is not significant. Depression is not significant. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania/manic behavior is not significant. Patient is responding to treatment plan. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

### Risk Assessment

#### CURRENT ENCOUNTER

Risk Assessments
Patient denies suicidal ideation, plan, intent, and/or attempt.
Patient denies property damage ideation, plan, intent, and/or attempt.
Patient denies homicidal ideation, plan, intent, and/or attempt.

#### RISK ASSESSMENT HISTORY

Risk	Current	Past	Documented	Event Date	Approximate Date	Ideation	Plan	Intent	Scale
Suicide	Denies		03/31/2022	03/31/2022	No				
Property	Denies		03/31/2022	03/31/2022	No				
Homicide	Denies		03/31/2022	03/31/2022	No				

Attempt	Planned/ Impulsive	Drug/Alcohol Influenced	Medically Treated	Plan Attempt Description
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#### SAFETY MANAGEMENT PLAN

No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

#### Assessment/Diagnosis

##### AXIS IV

Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

##### AXIS V

Current GAF: 70

Date: 07/01/2021.

Highest GAF: 70

Date: 05/03/2021.

#### Plan and Additional Information

Date	Order Description
06/29/2022	MHP follow-up for MH Monitoring

#### SIGNATURES

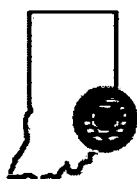
Staff: Signed by Leticia Martinez Mateos, MSW, LSW on 04/01/2022

#### Behavioral Health Billing

Start time: 10AM  
End time: 10:50AM  
Modifier: N/A

Document generated by: Leticia Martinez Mateos 04/01/2022 01:43 PM

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Indianapolis, IN 46204



**State of Indiana**

**Department of Correction**

Division of Medical and Clinical Healthcare Services

Indiana Government Center South  
302 W. Washington Street  
Indianapolis, IN 46204

**Facility: CIC**

PATIENT: JONATHAN RICHARDSON  
DATE OF BIRTH: [REDACTED]  
DOC #: 127630  
DATE: 03/02/2022 3:05 PM  
HISTORIAN: self  
VISIT TYPE: Onsite Consult

**Individual Counsel/Psych Prog Note**

**General**

Program Name: Outpatient

HCR#: 278753

Start time: 1pm

**MENTAL STATUS EXAM**

**GENERAL OBSERVATIONS:**

Generally normal

Appearance: Within normal limits

Build/Stature: Within normal limits

Posture: Within normal limits

Eye Contact: Average

Activity: Within normal limits

Attitude toward examiner: Cooperative

Attitude toward parent/guardian: Not Applicable

Separation (for children/adolescent): Not applicable

**MENTAL STATUS:**

Unremarkable

Mood: Euthymic

Affect: Full

Speech: Clear

Thought process: Logical

Perception: WNL

Hallucination: Denied None evidenced

Thought content: Within normal limits

Delusions: None Reported

Cognition: Within normal limits

Patient Name: RICHARDSON, JONATHAN  
ID: 127630 Date of Birth: [REDACTED]

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Encounter Date: 03/02/2022 03:05 PM

STATE001299

Intelligence estimate: Average  
Insight: Within normal limits  
Judgment: Within normal limits

### Subjective Information

New issues/stressors/extraordinary events presented today: New issue resolved, no update required

Explanation: Patient was seen in MHP's office for his HCR submitted 2/27/22, received/screened 2/28/22 (routine), stating "I would like to speak with Ms. Martinez, thanks in advance". During session, patient spoke about a recent incident in which he was called a "fag" by another offender. Patient stated he reported it to staff. She acknowledged that she has traits of being "manipulative" and spoke about those behavior patterns.

### Goals, Objectives, and Interventions Addressed Today

Goal Today	Objective Today
Depressive symptoms do not impair daily functioning	Identifies negative thinking supporting depression

#### Interventions/Methods Provided:

Actively listened to patient as she spoke about her "manipulative" traits.  
Praised patient for her resiliency.  
Challenged patient's belief that she is manipulative.  
Inquired about her coping skills and strengths.

#### Response to Interventions/Progress Toward Goals and Objectives:

Patient remained cooperative and respectful throughout the session. She was receptive to feedback given by MHP.

### Current Assessment

Individual's progress: Some progress

#### Assessment

Anxiety is not significant. Cognitive issues are not significant. Substance abuse/dependence is not significant. Depression is significant. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania/manic behavior is not significant. Patient is responding to treatment plan. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

### Risk Assessment

#### CURRENT ENCOUNTER

Risk Assessments
Patient denies suicidal ideation, plan, intent, and/or attempt.
Patient denies property damage ideation, plan, intent, and/or attempt.
Patient denies homicidal ideation, plan, intent, and/or attempt.

#### RISK ASSESSMENT HISTORY

Risk	Current	Past	Documented	Event Date	Approximate Date	Ideation	Plan	Intent	Scale
Suicide	Denies		03/02/2022	03/02/2022	No				
Property	Denies		03/02/2022	03/02/2022	No				
Homicide	Denies		03/02/2022	03/02/2022	No				

Attempt	Planned/ Impulsive	Drug/Alcohol Influenced	Medically Treated	Plan Attempt	Description
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Patient Name: RICHARDSON, JONATHAN  
ID: 127630 Date of Birth: [REDACTED]

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Encounter Date: 03/02/2022 03:05 PM

**SAFETY MANAGEMENT PLAN**

No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

**Assessment/Diagnosis**

**AXIS IV**

Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

**AXIS V**

Current GAF: 70

Date: 07/01/2021.

Highest GAF: 70

Date: 05/03/2021.

**Plan and Additional Information**

Date	Order Description
05/31/2022	MHP follow-up for MH monitoring

**SIGNATURES**

Staff: Signed by Leticia Martinez Mateos, MSW, LSW on 03/02/2022

**Behavioral Health Billing**

Start time: 1pm  
End time: 1:45pm  
Modifier: N/A

Document generated by: Leticia Martinez Mateos 03/02/2022 03:20 PM

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302 W. Washington Street  
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Patient Name: RICHARDSON, JONATHAN  
ID: 127630 Date of Birth: [REDACTED]

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Encounter Date: 03/02/2022 03:05 PM

STATE001301



# State of Indiana

Department of Correction

Division of Medical and Clinical Healthcare Services

Indiana Government Center South  
302 W. Washington Street  
Indianapolis, IN 46204

Facility: CIC

PATIENT: JONATHAN RICHARDSON  
DATE OF BIRTH: [REDACTED]  
DOC#: 127630  
DATE: 02/08/2022 01:55 PM  
VISIT TYPE: Provider Visit

Established patient

## PROBLEM LIST:

Problem Description	Onset Date	Chronic	Clinical Status	Notes
Gender identity disorder of adulthood	06/17/2020	N		
Gastroesophageal reflux disease	02/19/2015	Y		Mapped from KBM Chronic Conditions table on 05/09/2016 by the ICD9 to SNOMED Bulk Mapping Utility. The mapped diagnosis code was Esophageal reflux, 530.81, added by Paul A. Talbot, MD, with responsible provider Paul A. Talbot MD. Onset date 02/19/2015.
Borderline personality disorder	05/04/2010	Y		Mapped from KBM Chronic Conditions table on 05/09/2016 by the ICD9 to SNOMED Bulk Mapping Utility. The mapped diagnosis code was Borderline personality disorder, 301.83, added by Darla Hinshaw, MD, with responsible provider . Onset date 05/04/2010; Axis II.
Recurrent major depressive episodes, mild	10/21/2019	N		

## Problem List (not yet mapped to SNOMED-CT®):

Problem Description	Onset Date	Notes
Asthma	03/19/2007	
Polysubstance Dependence	01/17/2011	
major depression in remission	01/17/2011	
Nonspecific reaction to tuberculin skin test witho	02/01/2011	
Epilepsy	06/11/2015	

## Allergies

Ingredient	Reaction	Medication Name	Comment
PENICILLINS	Rash		
IBUPROFEN	Rash		

RICHARDSON, JONATHAN 127630 [REDACTED] 02/08/2022 01:55 PM 281/291

# 1183

CEFTRIAZONE SODIUM

SOB, chest pressure,  
rash ROCEPHINPt was given  
0.5mg Epi x1  
and NS IV w/  
good results

## Review of Systems

System	Neg/Pos	Details
Constitutional	Negative	Chills, fatigue, fever, malaise, night sweats, weight gain and weight loss.
ENMT	Negative	Ear drainage, hearing loss, nasal drainage, otalgia, sinus pressure and sore throat.
Eyes	Negative	Eye discharge, eye pain and vision changes.
Respiratory	Negative	Chronic cough, cough, dyspnea, known TB exposure and wheezing.
Cardio	Negative	Chest pain, claudication, edema and irregular heartbeat/palpitations.
GI	Negative	Abdominal pain, blood in stool, change in stool pattern, constipation, decreased appetite, diarrhea, heartburn, nausea and vomiting.
GU	Negative	Dribbling, dysuria, erectile dysfunction, hematuria, polyuria, slow stream, urinary frequency, urinary incontinence and urinary retention.
Endocrine	Negative	Cold intolerance, heat intolerance, polydipsia and polyphagia.
Neuro	Negative	Dizziness, extremity weakness, gait disturbance, headache, memory impairment, numbness in extremity, seizures and tremors.
Psych	Negative	Anxiety, depression and insomnia.
Integumentary	Negative	Brittle hair, brittle nails, change in shape/size of mole(s), hair loss, hirsutism, hives, pruritus, rash and skin lesion.
MS	Positive	Joint pain.
MS	Negative	Back pain, joint swelling, muscle weakness and neck pain.
Hema/Lymph	Negative	Easy bleeding, easy bruising and lymphadenopathy.
Allergic/Immuno	Negative	Contact allergy, environmental allergies, food allergies and seasonal allergies.
Reproductive	Negative	Penile discharge and sexual dysfunction.

All other review of systems are negative.

## Vital Signs

## Height

Time	ft	in	cm	Last Measured	Height Position
2:04 PM	5.0	11.0		02/08/2014	0

## Weight/BSA/BMI

Time	lb	oz	kg	Context	BMI kg/m2	BSA m2
2:04 PM	231.0		104.780	dressed with shoes	32.21	2.29

## Blood Pressure

Time	BP mm/Hg	Position	Side	Site	Method	Cuff Size
2:04 PM	120/78	sitting	left	arm	manual	adult

## Temperature/Pulse/Respiration

Time	Temp F	Temp C	Temp Site	Pulse/min	Pattern	Resp/min
2:04 PM	97.70	36.5	temporal	82	regular	18

## Pulse Oximetry/FIO2

Time	Pulse Ox (Rest %)	Pulse Ox (Amb %)	O2 Sat	O2 L/Min	Timing	FIO2 %	L/min	Delivery Method	Finger Probe
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2:04 PM 97 RA

RICHARDSON, JONATHAN 127630 02/08/2022 01:55 PM 282/291



# Measured By

Time Measured by  
2:04 PM Elizabeth A. Holloway, MHC

# Physical Exam

Exam	Findings	Details
General Exam	Comments	+Finkelstein's on L
Constitutional	Normal	Well developed.
Eyes	Normal	Conjunctiva - Right: Normal, Left: Normal. Pupil - Right: Normal.
Nose/Mouth/Throat	Normal	Oropharynx - Normal.
Neck Exam	Normal	Inspection - Normal.
Respiratory	Normal	Inspection - Normal. Auscultation - Normal. Effort - Normal.
Cardiovascular	Normal	Regular rhythm. No murmurs, gallops, or rubs.
Vascular	Normal	Capillary refill - Less than 2 seconds.
Abdomen	Normal	Inspection - Normal. Auscultation - Normal. No abdominal tenderness. No hepatic enlargement. No spleen enlargement. No hernia.
Musculoskeletal	Normal	Visual overview of all four extremities is normal.
Extremity	Normal	No edema.
Neurological	Normal	Memory - Normal. Cranial nerves - Cranial nerves II through XII grossly intact.
Psychiatric	Normal	Orientation - Oriented to time, place, person & situation. Appropriate mood and affect. Normal insight. Normal judgment.

# Suicide Risk Screening

# Assessment/Plan

#	Detail Type	Description
1.	Assessment	Carpal tunnel syndrome (354.0), left.
	Patient Plan	Brace Prednisone Tylenol
	Provider Plan	The patient verbalized an understanding of the plan.
	Plan Orders	splint/brace - wrist on 02/08/2022.

# Labs

Date Ordered	Status	Test Status	Description	Order#	Provider	Test Location
02/08/2022 09:54 AM	Ordered	Pending	COMPREHENSIVE METABOLIC PANEL / CBC WITH DIFF / LIPID 8 (CARDIAC) PANEL(INCL CHOLESTEROL, TRIG, HDL, LDL) / URINALYSIS / TESTOSTERONE, TOTAL / ESTRADIOL / PROLACTIN	1146786	Jones, John	CIC

# Medications (Added, Continued or Stopped this visit)

Start Date	Medication	Directions	PRN Status	PRN Reason	Instruction	Stop Date
12/17/2021	estradiol 2 mg	take 1 tablet by oral route	N		FER submitted	06/14/2022
RICHARDSON, JONATHAN 127630 02/08/2022 01:55 PM 283/291						

02/08/2022	tablet prednisone 10 mg tablet	every day Taper 6/5/4/3/2/1.	N	KOP	02/13/2022
09/27/2021	Proventil HFA 90 mcg/actuation aerosol inhaler	inhale 2 puff by inhalation route every 4 - 6 hours as needed	Y	DO NOT SEND - MAX REFILL ONCE Q 3-4M KOP	03/25/2022
10/21/2021	spironolactone 50 mg tablet	take 1 tablet by oral route every day	N	KOP	04/18/2022
02/08/2022	Tylenol Extra Strength 500 mg tablet	take 1 tablet by oral route every 8 hours as needed	N	KOP	05/08/2022

**Provider:**

Jones, John 02/08/2022 2:04 PM

Document generated by: Elizabeth A. Holloway, MHC 02/08/2022 02:04 PM

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302 W. Washington Street  
Indianapolis, IN 46204



**State of Indiana**

Department of Correction

Division of Medical and Clinical Healthcare Services

Indiana Government Center South  
302 W. Washington Street  
Indianapolis, IN 46204

**Facility: CIC**

PATIENT: JONATHAN RICHARDSON  
DATE OF BIRTH: [REDACTED]  
DOC #: 127630  
DATE: 02/01/2022 11:53 AM  
VISIT TYPE: Nurse Visit

**Nurse Visit**

Reason for visit: Numbness  
HCR#: 11025

Statement of complaint (in patient's words): "Numbness in left hand"

**Vital Signs**

**Weight/BSA/BMI**

Time	lb	oz	kg	Context	BMI kg/m2	BSA m2
11:55 AM	213.0		96.615	dressed with shoes		

**Blood Pressure**

Time	BP mm/Hg	Position	Side	Site	Method	Cuff Size
11:55 AM	128/82	sitting	left	arm	manual	adult

**Temperature/Pulse/Respiration**

Time	Temp F	Temp C	Temp Site	Pulse/min	Pattern	Resp/min
11:55 AM	97.50	36.4		97	regular	18

**Pulse Oximetry/FIO2**

Time	Pulse Ox (Rest %)	Pulse Ox (Amb %)	O2 Sat	O2 L/Min	Timing	FIO2 %	L/min	Delivery Method	Finger Probe
11:55 AM	97		RA			21			

**Measured By**

Time	Measured by
11:55 AM	Jodean Ayres, RN

Patient Name: RICHARDSON, JONATHAN  
ID: 127630 Date of Birth: [REDACTED]

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Encounter Date: 02/01/2022 11:53 AM

STATE001306

**Nurse Protocols:**

**MUSCULOSKELETAL**

**Subjective:**

Date of Onset: 02/01/2022.

Previous history? Yes.

Recent injury? No.

Pain? Yes. Comments: Pins and needles feeling

**Objective:**

Examination of Left hand.

Tenderness? No.

Palpable distal pulses? Yes.

Pain with movement? No.

Sensation intact? No.

Spasms? No.

Range of motion (WNL)? Yes.

Weakness? Yes.

Discoloration? No.

Warm to touch? Yes.

Tingling? Yes.

Gait (WNL)? Yes.

Numbness? Yes.

Swelling? No.

Bowel & Bladder Function

N/A to complaint (no complaints of back pain).

Urine dipstick?: Not indicated.

**Assessment:**

Alteration in comfort

Related to: strain/sprain.

**Review/Comments**

Patient smokes 16.00 packs a year

**Medications**

Medication	Sig	PRN Status	PRN Reason	Comment
estradiol 2 mg tablet	take 1 tablet by oral route every day	N		
Proventil HFA 90 mcg/actuation aerosol inhaler	inhale 2 puff by inhalation route every 4 - 6 hours as needed	Y		
spironolactone 50 mg tablet	take 1 tablet by oral route every day	N		

Patient Name: RICHARDSON, JONATHAN  
ID: 127630 Date of [REDACTED]

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Encounter Date: 02/01/2022 11:53 AM

STATE001307

#### Orders

Status	Order	Timeframe	Frequency	Duration	Stop Date
ordered	Referred to provider - condition not responding to protocol	Routine			
completed	Patient education provided				
completed	Sick call if symptoms do not subside or become more severe				

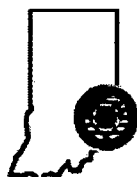
#### General Comments

39yr old male presents to medical from the kitchen with complaints of having weakness and numbness in his left hand. Pt reports having issue all the time with periods of weakness / numbness then it returns to normal. Pt has ROM in hand / fingers. Pins and needles feeling. He reports at this time the numbness is lasting longer. Pt refer to MD for assessment.

Education	Date Provided	Provided By
Patient education provided	02/01/2022	Jodean Ayres, RN

Document generated by: Jodean Ayres, RN 02/01/2022 12:03 PM

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302 W. Washington Street  
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**State of Indiana**

**Department of Correction**

**Division of Medical and Clinical Healthcare Services**

**Indiana Government Center South  
302 W. Washington Street  
Indianapolis, IN 46204**

**Facility: CIC**

PATIENT: JONATHAN RICHARDSON  
DATE OF BIRTH: [REDACTED]  
DOC #: 127630  
DATE: 01/24/2022 9:09 AM  
HISTORIAN: self  
VISIT TYPE: Onsite Consult

**Individual Counsel/Psych Prog Note**

**General**

Program Name: Outpatient

HCR#: 12150

Start time: 10:30AM

**MENTAL STATUS EXAM**

**GENERAL OBSERVATIONS:**

Generally normal

Appearance: Within normal limits

Build/Stature: Within normal limits

Posture: Within normal limits

Eye Contact: Average

Activity: Within normal limits

Attitude toward examiner: Cooperative

Attitude toward parent/guardian: Not Applicable

Separation (for children/adolescent): Not applicable

**MENTAL STATUS:**

Unremarkable

Mood: Euthymic

Affect: Full

Speech: Clear

Thought process: Logical

Perception: WNL

Hallucination: Denied None evidenced

Thought content: Within normal limits

Delusions: None Reported

Cognition: Within normal limits

Patient Name: RICHARDSON, JONATHAN

ID: 127630 Date of Birth: [REDACTED]

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Encounter Date: 01/24/2022 09:09 AM

STATE001309

Intelligence estimate: Average  
 Insight: Within normal limits  
 Judgment: Within normal limits

### Subjective Information

New issues/stressors/extraordinary events presented today: New issue resolved, no update required

Explanation: Patient was seen in MHP's office for his HCR submitted 1/3/22, received/screened 1/4/22 (routine), stating "I would like to see Ms. Martinez, please." During session, patient stated that she has been trying to "work on" her femininity. She described trying to make her voice sound more high pitched as her natural voice is deeper. She stated that she looks forward to being released from prison so that she may continue her physical transition into womanhood. She described being more comfortable in her own skin and acknowledged that she feels less afraid of showing her feminine side.

### Goals, Objectives, and Interventions Addressed Today

Goal Today	Objective Today
Mismatch between assigned gender and gender identity no longer causes marked distress.	Identify ways in which gender identity leads to distress, exacerbates symptoms of depression, and contributes to other concerns such as irritability and self-destructive behavior.

#### Interventions/Methods Provided:

Practiced active listening as patient discussed her coping strategies  
 Validated her thoughts and emotions given the transition she is currently making  
 Developed positive affirmations to remind patient of her strengths.

#### Response to Interventions/Progress Toward Goals and Objectives:

Patient remained cooperative and respectful throughout the session. She was receptive to feedback given by MHP.

### Current Assessment

Individual's progress: Some progress

#### Assessment

Anxiety is significant. Cognitive issues are not significant. Substance abuse/dependence is not significant. Depression is significant. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania/manic behavior is not significant. Patient is responding to treatment plan. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

### Risk Assessment

#### CURRENT ENCOUNTER

Risk Assessments
Patient denies suicidal ideation, plan, intent, and/or attempt.
Patient denies property damage ideation, plan, intent, and/or attempt.
Patient denies homicidal ideation, plan, intent, and/or attempt.

#### RISK ASSESSMENT HISTORY

Risk	Current	Past	Documented	Event Date	Approximate Date	Ideation	Plan	Intent	Scale
Suicide	Denies		01/24/2022	01/24/2022	No				
Property	Denies		01/24/2022	01/24/2022	No				
Homicide	Denies		01/24/2022	01/24/2022	No				

Patient Name: RICHARDSON, JONATHAN  
 ID: 127630 Date of Birth: [REDACTED]

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Attempt	Planned/ Impulsive	Drug/Alcohol Influenced	Medically Treated	Plan Attempt	Description
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#### SAFETY MANAGEMENT PLAN

No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

#### Assessment/Diagnosis

##### AXIS IV

Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

##### AXIS V

Current GAF: 70

Date: 07/01/2021.

Highest GAF: 70

Date: 05/03/2021.

#### Plan and Additional Information

Date	Order Description
04/24/2022	MHP follow-up for MH Monitoring

#### SIGNATURES

Staff: Signed by Leticia Martinez Mateos, MSW, LSW on 01/26/2022

#### Behavioral Health Billing

Start time: 10:30AM  
End time: 10:55AM  
Modifier: N/A

Document generated by: Leticia Martinez Mateos 01/26/2022 03:28 PM

Indiana Government Center South  
302 W. Washington Street  
Indianapolis, IN 46204

Patient Name: RICHARDSON, JONATHAN  
ID: 127630 Date of Birth: [REDACTED]

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